



INSTRUCTIONS AND REQUIREMENTS FOR REINSTATEMENT / REACTIVATION SOUTH CAROLINA ADVANCED PRACTICE REGISTERED NURSE (APRN) LICENSE

Information for Applicant

South Carolina is a member of the Nurse Licensure Compact (NLC). The NLC does not affect additional requirements imposed by states for advanced-practice registered nursing. A multi-state licensure privilege to practice registered nursing granted by a party state must be recognized by other party states as a license to practice registered nursing if a license to practice registered nursing is required by state law as a precondition for qualifying for advanced-practice registered nurse authorization.

A current South Carolina APRN license or temporary license is required to practice advanced nursing in this state. Orientation is considered the practice of nursing in South Carolina. Therefore, all nurses must possess a current South Carolina license and/or temporary license before beginning orientation (including classroom instruction and reading policies and procedures). It is a violation of the Nurse Practice Act to begin orientation without the proper license and can result in action by the Board. Please visit our website at www.llr.state.sc.us/pol/nursing to review the complete South Carolina Nurse Practice Act, Chapter 33, Section 40-33-34 for more details on educational and certification requirements.

South Carolina Nurse Practice Act §40-33-20. Definitions.

(31) "Inactive license" means the official temporary retirement of a person's authorization to practice nursing upon the person's notice to the board that the person does not plan to practice nursing or the status of a license that does not currently authorize a licensee to practice nursing in this State.

(34) "Lapsed license" means the termination of a person's authorization to practice nursing due to the person's failure to renew his or her nursing license within the renewal period.

The Board may reinstate/reactivate an APRN licensee from inactive/lapsed status upon payment of reactivation/reinstatement fee and furnish evidence satisfactory that applicant has met requirements for licensure as provided in §40-33-34.

An applicant for licensure as an Advanced Practice Registered Nurse (APRN) shall furnish evidence satisfactory to the board that the applicant:

- (1) has met all qualifications for licensure as a registered nurse; and
- (2) holds current specialty certification by a board-approved credentialing organization. New graduates shall provide evidence of certification within one year of program completion; however, psychiatric clinical nurse specialists shall provide evidence of certification within two years of program completion; and
- (3) has earned a master's degree from an accredited college or university, except for those applicants who:
 - (a) provide documentation as requested by the board that the applicant was graduated from an advanced, organized formal education program appropriate to the practice and acceptable to the board before December 31, 1994; or
 - (b) graduated before December 31, 2003, from an advanced, organized formal education program for nurse anesthetists accredited by the national accrediting organization of that specialty. CRNA's who graduate after December 31, 2003, must graduate with a master's degree from a formal CRNA education program for nurse anesthetists accredited by the national accreditation organization of the CRNA specialty. An advanced practice registered nurse must achieve and maintain national certification, as recognized by the board, in an advanced practice registered nursing specialty;
- (4) has paid the board all applicable fees; and

- (5) has declared specialty area of nursing practice and the specialty title to be used must be the title which is granted by the board-approved credentialing organization or the title of the specialty area of nursing practice in which the nurse has received advanced educational preparation.

Prescriptive Authority: APRN's applying for prescriptive authority shall meet the requirements as noted in the S.C. Nurse Practice Act, Section 40-33-34 (E).

In order to change the status of your license from Inactive/Lapsed Status to Active Status, you must do the following: Complete and submit the APRN reinstatement/reactivation application and if applicable, Prescriptive Authority application. **Application fees are non-refundable.** Money order, cashier's check or personal check should be made payable to **LLR-Board of Nursing**.

Your application must include the following:

1. Complete the Affidavit of Eligibility
2. Complete the Criminal Background process.
3. Recent 2"x 2" full faced passport type photo, sign and date on front or back and tape along top edge only onto your application.
4. Copy of your current state license
5. Copy of current specialty certification by a board-approved credentialing organization.
6. Copies of legal documents that authorize a change in name, if applicable.
7. Obtain all physician signatures and license numbers to be included on your application, if applicable.
8. See the SC Nurse practice Act for guidelines on the development of written protocols.
9. If applying for Prescriptive Authority, complete and submit the following: Prescriptive Authority Application and documentation of continuing education hours in pharmacotherapeutics
10. Application fees – Money order, cashier's check or personal check made payable to LLR-Board of Nursing.
 - APRN Reinstatement of lapsed license \$90.00
 - APRN Reinstatement of lapsed license with Prescriptive Authority \$110.00
 - APRN Reactivation of inactive license \$70.00
 - APRN Reactivation of inactive license with Prescriptive Authority \$90.00



Criminal Background Check (CBC)

Effective March 2, 2009, an applicant for a license to practice nursing in South Carolina shall be subject to a criminal history background check as defined in [40-33-25](#) of the Nursing Practice Act.

This process requires you to furnish a full set of fingerprints and additional information required to enable a criminal history background check to be conducted by the State Law Enforcement Division (SLED) and the Federal Bureau of Investigation (FBI). These services are provided by Identogo Centers and are operated by MorphoTrust USA.

Residents of South Carolina should go online to schedule for fingerprinting services:

<http://www.identogo.com/FP/SouthCarolina.aspx> or call (866) 254-2366 for assistance in scheduling. Scheduling services will provide detailed information of forms of identification that will be required.

If you are a non-resident of South Carolina and do not reside in an area near South Carolina, please follow the **Non-Resident Card Scan Processing Procedures** below.

Non-Resident Card Scan Processing Procedures

For applicants that reside out of South Carolina who wish to use the Identogo/Morpho Trust USA Centers, you may use these centers that are located in South Carolina only. If an applicant does not reside near South Carolina, they must complete and submit the fingerprint cards by following the directions below. This program utilizes advanced scanning technology to convert a traditional fingerprint card (hard card) into an electronic fingerprint record. The section below details the procedures for submitting fingerprints to the MorphoTrust card scan department. Applicant should contact Identogo/MorphoTrust (866-254-2366) to verify the current fee to submit.

- Applicants should obtain a set of fingerprints from a local law enforcement agency or other entity that provides fingerprinting services. These fingerprint cards may be either traditional ink rolled fingerprints or electronically captured and printed fingerprint cards.
- Fingerprints may be submitted on FBI applicant cards. The applicant may call or email the Nursing Board to have the FBI applicant cards mailed to them. Phone: 803-896-4550 or email: nurseboard@llr.sc.gov. Due to agency specific information, MorphoTrust USA does not provide fingerprint cards to applicants.
- Applicant should ensure the fingerprint cards are completely filled out. Required information includes:
 - ORI Number: **SC920112Z**
 - Full Name
 - Home Address
 - Place of Birth (State or Country Only)
 - Citizenship
 - Social Security Number
 - Date of Birth
 - Sex, Height, Weight, Hair Color and Eye Color
 - Reason fingerprinted
- Mail the fully completed card and applicable fee (Include full name of applicant on the check) to:

MORPHOTRUST USA
ATTN: SC Card Scan
3051 HOLLIS DR SUITE 310
Springfield, IL 62704

Follow-up calls and questions on the processing of a fingerprint card should be made directly to Identogo/MorphoTrust at (866) 254-2366 and speak to a customer service representative.

DO NOT return fingerprint card or fingerprint processing fee in with your application or to the Board of Nursing. This will delay the processing of your application.



South Carolina Department of Labor, Licensing and Regulation

South Carolina Board of Nursing

P.O. Box 12367 • Columbia, SC 29211

Phone: 803-896-4550 • Fax: 803-896-4515 • www.llronline.com/POL/nursing/



APRN REINSTATEMENT/ REACTIVATION APPLICATION

Check all that apply: ☐ Reinstatement ☐ Reactivation ☐ Prescriptive Authority

South Carolina is a member of the Nurse Licensure Compact (NLC). Advanced practice is recognized as a single state license only. Please visit www.ncsbn.org for more information or for a current list of Compact States. Please print. Answer all questions and submit with proper fee. Careful completion of this application will avoid a delay in processing. Personal information provided in this application may be subject to public scrutiny or released under the SC Freedom of Information Act or other provisions of federal and state law. The Social Security Number (SSN) is not subject to disclosure as public information. The disclosure of the SSN for identification purposes is authorized and mandated by federal statutes requiring state boards to report to the National Practitioner Data Bank (NPDB), among other things. The South Carolina Code of Laws requires that every individual who applies for an occupational or professional license provide a social security or alien identification number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

Social Security Number: _____ - _____ - _____

Full Legal Name: _____
First Middle Maiden (if married) Last

Mailing Address: _____
Street/PO Box City State Zip

Home Address: _____
Street (physical address required) City State Zip

County: _____ Email Address: _____

Telephone #: _____ Date of Birth: _____ Place of Birth: _____

Race: (for statistical purposes only)

☐ American Indian ☐ African American ☐ Caucasian ☐ Hispanic ☐ Oriental/Asian ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Sex: ☐ Female ☐ Male

Declaration of Primary State of Residence: (where I hold a driver's license, pay taxes or vote)

I declare my primary state of residence is _____ I plan to primarily practice in the state of _____

I am in the military or federal government. I am currently licensed in _____ (state) and I do not intend to work outside of military or federal government.

Remit fee by money order, cashier check or personal check, made payable to LLR-Board of Nursing with application. For a legal name change, include documented proof (required- marriage license, divorce decree or court document). The application fee is non-refundable. Check only one box below.

- ☐ APRN Reinstatement of lapsed license \$90.00
- ☐ APRN Reinstatement of lapsed license with Prescriptive Authority \$110.00
- ☐ APRN Reactivation of inactive license \$70.00
- ☐ APRN Reactivation of inactive license with Prescriptive Authority \$90.00

Attach original recent
2 x 2 passport photo

Sign and date photo
on left side

Tape on top edge only

Do not staple

Personal History Information

If you answer "yes" to any of the questions below (1-10), you must attach a full written explanation pertaining to that particular question.

1. Have you ever had any application for any professional license, certification, or registration refused or denied by any licensing authority?	YES <input type="checkbox"/> NO <input type="checkbox"/>
2. Have you ever been refused or denied the privilege of taking an examination required for any professional license?	YES <input type="checkbox"/> NO <input type="checkbox"/>
3. Have you ever been the subject of disciplinary action with regard to a license, been revoked or sanctioned by any licensing authority, association, licensed facility, or staff of such facility?	YES <input type="checkbox"/> NO <input type="checkbox"/>
4. Have your privileges ever been restricted or terminated by any association, licensed facility, or staff of such facility; or have you ever voluntarily or involuntarily resigned or withdrawn from such association or facility to avoid imposition of such measures?	YES <input type="checkbox"/> NO <input type="checkbox"/>
5. To your knowledge have any unresolved or pending complaints ever been filed against you with any federal or state agency, professional association, licensed hospital or clinic, or staff of such hospital or clinic?	YES <input type="checkbox"/> NO <input type="checkbox"/>
6. Have you ever been arrested, charged or convicted (including a nolo contendere plea or guilty plea) in any state or federal court (other than minor traffic violations) whether or not sentence was imposed or suspended? If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense, date of discharge, if applicable, as well as a statement from the probation or parole officer sent directly to the Board from the above-mentioned authorities.	YES <input type="checkbox"/> NO <input type="checkbox"/>
7. Currently are you being treated or within the last five years, have you been treated for drug or alcohol addiction that might interfere with your ability to competently and safely perform the essential functions of practice?	YES <input type="checkbox"/> NO <input type="checkbox"/>
8. Currently or within the last five years, have you been treated for any physical, mental or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice?	YES <input type="checkbox"/> NO <input type="checkbox"/>
9. Currently or within the last five years, have you developed any disease or conditions, physical, mental, or emotional that might interfere with your ability to competently and safely perform the essential functions of practice?	YES <input type="checkbox"/> NO <input type="checkbox"/>
10. a. Have you ever voluntarily surrendered a nursing license? b. Have you ever voluntarily surrendered a controlled substance or DEA registration?	YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA <input type="checkbox"/>
11. a. Do you plan to prescribe Schedules III through V? b. Do you have a controlled substance or DEA registration?	YES <input type="checkbox"/> NO <input type="checkbox"/> NA <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NA <input type="checkbox"/>

Specialty Area(s) & Certification(s)

1. Specialty area of APRN practice.	
2. Describe your specialty area in advanced nursing practice. (This section will be assessed by an Advanced Practice Nursing Consultant who will determine the closest scope of practice area in accordance with National Certification)	
3. Do you hold current specialty certification by a national credentialing organization(s)? Certifying Organization _____ Expiration date _____ (Attached a copy of certificate)	YES <input type="checkbox"/> NO <input type="checkbox"/>

Other

Check here if you are trained and willing to volunteer your services during a bioterrorism disaster?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Check here if you are trained and willing to volunteer your services during a disaster?	YES <input type="checkbox"/> NO <input type="checkbox"/>

Advanced Practice Employment (Current)

PRIMARY Practice Site (If more than 2 sites, duplicate form as needed)	Employer Name (Use blank copies of this form to add multiple practice sites and/or physicians):	
	Practice Address: (Street, City, State, Zip Code)	
* Supervising Physician: <input type="checkbox"/> Primary Physician <input type="checkbox"/> Alternate Supervising Physician	Supervising Physician (All physicians must have a permanent SC license in good standing)	Proximity to NP, CNM, CNS in Miles:
	Business Address: (Street, City, State, Zip)	
SC Physician's License No:	Practice Specialty:	Primary Practice Site Phone Number

 Signature of Supervising Physician * _____
Date

SECONDARY/ADDITIONAL Practice Site (If more than 2 sites, duplicate form as needed)	Employer Name:	
	Practice Address: (Street, City, State, Zip)	
* Supervising Physician: <input type="checkbox"/> Primary Physician <input type="checkbox"/> Alternate Supervising Physician	Supervising Physician (All physicians must have a permanent SC license in good standing)	Proximity to NP, CNM, CNS in Miles:
	Business Address: (Street, City, State, Zip)	
SC Physician's License No:	Practice Specialty:	Secondary Practice Site Phone Number

 Signature of Supervising Physician * _____
Date

A copy of practice protocols, for NP, CNM, or CNS/ copy of written approved guidelines for CRNA signed and dated by all the physicians listed above and myself are on file in the office/agency of my employment and available upon request.
 YES ☐ NO ☐

*** Note:** Pursuant to §40-33-34(H)(2)(a)(ii), in addition to the supervising physician or dentist, CRNAs may also have the physician director of anesthesia services or the medical director of the facility sign this form.

Name _____
www.llr.state.sc.us/pol/nursing

I, _____, am the person described and identified, of good moral character, and the person named in all documents presented in support of this application. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this application, I hereby agree that such act shall constitute the cause for denial or revocation of my license to practice in South Carolina.

Signature of applicant (do not print)

Date

Printed name of applicant (first, middle, maiden, last)

Subscribed and sworn before me this _____ day of _____, _____

(Signature of notary public)

My commission expires

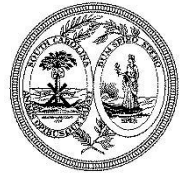
Remember to:

- ☐ Complete and answer all questions; Sign, date and have your application notarized
- ☐ Complete the Affidavit of Eligibility
- ☐ Complete the Criminal Background process
- ☐ Recent 2"x 2" full faced passport type photo, sign and date on front or back and tape along top edge only onto your application
- ☐ Copy of your current state license, other than SC
- ☐ Copy of current specialty certification by a board-approved credentialing organization
- ☐ Copies of legal documents that authorize a change in name, if applicable
- ☐ Obtain all physician signatures and license numbers to be included on your application, if applicable. See the SC Nurse Practice Act for guidelines on the development of written protocols.
- ☐ If applying for Prescriptive Authority, please complete and submit the following: Prescriptive Authority Application and certificates of continuing education hours in pharmacotherapeutics (see statute for specific guidelines).
- ☐ Complete the requirements for the criminal background check
- ☐ Provide proof of residence- copy of driver's license or voter registration card

Once all requirements have been met, your license may be reactivated or reinstated within 10 business days. During peak times, the application review/approval process may take longer.



STATE OF SOUTH CAROLINA
DEPARTMENT OF LABOR, LICENSING AND REGULATION
**VERIFICATION OF LAWFUL PRESENCE IN THE UNITED STATES
AFFIDAVIT OF ELIGIBILITY**



Pursuant to Section 8-29-10, *et seq.* of the South Carolina Code of Laws (1976, as amended), the Department of Labor, Licensing and Regulation must verify that any person who applies for a South Carolina license is lawfully present in the United States. Complete and sign this affidavit of eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

The undersigned _____, of _____
(Print clearly First, Middle, and Last name) (Home Address, City, State, and Zip Code)

being first duly sworn deposes and states as follows:

Check only one box:

1. ☐ I am a United States citizen; or
2. ☐ I am a Legal Permanent Resident of the United States eighteen years of age or older; or
3. ☐ I am a Qualified Alien or non-immigrant under the Federal Immigration and Nationality Act, Public Law 82-414, eighteen years of age or older, and lawfully present in the United States.
4. ☐ Other: _____ Please submit any documentation that supports this status.

Date of Birth: _____

Alien Number: _____

I-94 Number: _____

(If you checked number 2, 3, or 4 you must attach a copy of your immigration documents. See Instruction sheet for a list of accepted immigration documents.)

Section B: ATTESTATION.

I understand that in accordance with section 8-29-10 of the South Carolina Code of Laws, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall, in addition to other sanctions imposed by this State or the United States, be guilty of a felony, and upon conviction must be fined and/or imprisoned for not more than 5 years (or both).

I understand that the representations made in this Affidavit shall apply through any license(s) or renewals issued, and that I shall have an affirmative duty to immediately advise the Department of Labor, Licensing and Regulation of any change of my immigration or citizenship status.

I swear and attest the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension, or revocation of a license, certificate, registration or permit.

Signature of Affiant

SWORN to before me this _____ day of _____

Notary Public for _____

My Commission Expires: _____

INSTRUCTION SHEET FOR COMPLETING AFFIDAVIT OF ELIGIBILITY

CHECK box 1:

If you are a United States Citizen by birth or naturalization

CHECK box 2:

If you are a Legal Permanent Resident and you are not a U.S. Citizen, but are residing in the U.S. under legally recognized and lawfully recorded permanent residence as an immigrant.

PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

CHECK box 3:

If you are a Qualified Alien. You are a Qualified Alien if you are:

An alien who is lawfully admitted for residence under the INA.

An alien who is granted asylum under Section 208 of the INA.

A refugee who is admitted to the United States under Section 207 of the INA.

An alien who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least 1 year.

An alien whose deportation is being withheld under Section 243(h) of the INA (as in effect prior to April 1, 1997) or whose removal has been withheld under Section 241(b)(3).

An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980.

An alien who is a Cuban/Haitian Entrant as defined by Section 501(e) of the Refugee Education Assistance Act of 1980.

An alien who has been battered or subjected to extreme cruelty, or whose child or parent has been battered or subject to extreme cruelty.

PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

ACCEPTED IMMIGRATION DOCUMENTS:

Unexpired Reentry Permit (I-327)

Permanent Resident Card or Alien Registration Receipt Card With Photograph (I-551)

Unexpired Refugee Travel Document (I-571)

Unexpired Employment Authorization Card Which Contains a Photograph (I-688)

Machine Readable Immigrant Visa (with Temporary I-551 Language)

Temporary I-551 Stamp (on passport or I-94)

I-94 (Arrival/Departure Record) in Unexpired Foreign Passport

I-20 (Certificate of Eligibility for Nonimmigrant, F-1, Student Status)

DS2019 (Certificate of Eligibility for Exchange Visitor, J-1, Status)



South Carolina Board of Nursing

P.O. Box 12367 • Columbia, SC 29211

Phone: 803-896-4550 • Fax: 803-896-4515 • www.llronline.com/POL/nursing/**APPLICATION FOR PRESCRIPTIVE AUTHORITY**

FEES/ REQUIREMENTS: \$20 fee. Submit a check or money order payable to LLR SC Board of Nursing. **Incomplete applications will be returned. Fees are non-refundable.** To meet initial requirements for prescriptive authority, the applicant must provide evidence of 45 contact hours of pharmacotherapeutics, within the past two years from the date of the application and at 15 hours must be in controlled substances. Or, if the applicant is coming from another state with prescriptive authority, 20 contact hours of pharmacotherapeutics is needed and at least 15 hours must be in controlled substances. **See the SC Nurse Practice Act, Chapter 33, Section 40-33-34 (E) for details.** Transcripts must be sent directly from the university to the Board of Nursing. * The Social Security Number (SSN) is not subject to disclosure as public information. The disclosure of the SSN for identification purposes is authorized and mandated by federal statutes requiring state board to report to the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner (NPDN), among other things.

1. Full Legal Name: _____
Last First Middle Maiden
2. Mailing Address: _____
Street City State Zip
3. Home Phone: _____ 4. Social Security Number: _____
5. S.C. License No. _____ 6. Practice Specialty: _____
7. **Attach a copy of current national certification.**
8. **Primary Practice /Agency:** _____ Phone: _____
Address: _____
Street City State Zip

All physicians must have a permanent S.C. license which is in good standing. By signing this document, I affirm that I will not supervise any more than three NPs, CNMs or CNSs at any given time without prior approval by the SC Board of Nursing and SC Board of Medical Examiners, pursuant to S.C. Code Ann. §§ 40-33-34(C), 40-47-20(43) and 40-47-195(C).

9. **Supervising Physician:** _____ **S.C. License No.** _____
Business Address: _____
Street City State Zip
Practice Specialty: _____ County: _____
Work Phone _____ Proximity to Nurse in Miles: _____

(Attach Additional Pages for Additional Practice Sites)

Signature of Supervising Physician

- Alternate Supervising Physician:** _____ **S.C. License No.** _____
Business Address: _____
Street City State Zip
Practice Specialty: _____ County: _____
Work Phone _____ Proximity to Nurse in Miles: _____

(Attach Additional Pages for Additional Practice Sites)

Signature of Supervising Physician

I HEREBY swear/affirm the statements made in this application to be TRUE to the best of my knowledge.

Signature of Applicant

Date